

Department of Vermont Health Access

280 State Drive, NOB 1 South Waterbury, VT 05671-1010 www.dvha.vermont.gov [Phone] 802-879-5903 [Fax] 802-879-5963 Agency of Human Services

Interceptive Orthodontic Treatment Prior Authorization Request Form (Effective 9/2017)

Patient Name			
i auciit ivaiiic.			
Date of Birth:/	Age:		
Address:			
Parent(s) Name:			
Patient Medicaid I.D. Number: _			
Referring Dentist:			
Preventive and restorative treatm		es ⊔ No	
Oral Hygiene: Good Fai	ir 🗆 Poor		
Diagnosis:		-	
Dentition: \square Primary \square Tran		」 Adult	
Angle Class: ☐ I ☐ II ☐ II			
Overbite: mm	Overjet: mm	Crowding:	
		1 NOT 1 116 1	Mandibular mm
Diagnostic Treatment Criteria			
Maior Criteria:	*Minor criteria:	Note that opt	ion A & B cannot be on the same arch.
☐ Cleft palate	A□ 2 Blocked	cuspids, per arch (deficie	nt by at least 1/3 of needed space)
☐ Severe Skeletal Class III	$B\square$ Crowding.	per arch (10+mm)	
☐ Severe Cranio-Facial Syndro	_	•	h (excluding third molars)
(Tranchar Calling Syndrome	Open bite	Liteath par arch	` '
Marfan Syndrome, Pierre Ro	obin	cuspid	
Syndrome, etc. Specify:	□ Anterior cr	ossbite (3+teeth)	
syndrome, etc. speerry.	Traumatic		loto
Posterior crossbite (3+teeth)		mm (measured from labia	
Eligibility for interceptive ortho	odontic treatment requires the		to labial) were enough to meet a minimum of <i>1 major</i> (
*Eligibility for <u>interceptive orthogonal orthogonal or interceptive orthogonal orthogon</u>	odontic treatment requires the teria.		
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I certify that my examination of this patient and his/her diagnostic materials was conducted in conformance with the Laws and Regulations of

The Board of Dental Examiners of the Vermont Secretary of State Office of Professional Regulation, and that my diagnosis of his/her

condition as set forth herein is accurate to the best of my professional judgment.

Provider Signature: